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Spectral Ties: Hospital Hauntings Across the Line of Control

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ABSTRACT

In this article, we trace encounters between humans and phantasmic entities in hospitals in Indian-occupied and Pakistan-controlled Kashmir. In Pakistan, the presence of spectral beings (*jinni*) in hospitals is linked to state and sectarian violence, which precipitates ruptures between jinni and human worlds. Such breaches permit jinni to manifest in the medical present, where insecure actors harness them to ventriloquize unspoken anxieties. In Indian-occupied Kashmir, jinn-like, chronically mentally ill patients haunt psychiatric modernization projects. In embracing a jinneaological approach to medical crises, we theorize hospitals as multi-temporal and multi-dimensional spaces called "tesseracts," in which human-nonhuman encounters serve existential and political purposes.

KEYWORDS

Kashmir; South Asia; haunting; hospitals; infrastructure; political violence; subjectivity

> Doesn't a breath of the air that pervaded earlier days caress us as well? In the voices we hear, isn't there an echo of now silent ones? …. If so, there is a secret agreement between past generations and the present one. Then our coming was expected on earth.
>
> – Walter Benjamin (2003[1940]):390

Benjamin implores us to listen to echoes of silent voices, histories and spectral hauntings. Based on our fieldwork in Pakistan- and Indian-controlled Kashmir, we call for a hauntology, or more specifically, a "jinneaology" (Taneja 2013) of hospitals and public health settings. In Islamic theology, belief in the existence of *jinni* (pl. jinn) is a primary article of faith considered equivalent to belief in the existence of angels. Like Muslims the world over, Kashmiri Muslims believe jinni are a species of spiritual beings created by God out of smokeless fire. Jinni may cause suffering or positively intervene in human affairs; they live among us, yet are invisible and only occasionally discernible (El-Zoun 2009; Khan 2006). They are also invested in, and vulnerable to, human influence, such as prayer or sorcery.[1]

In Kashmir as elsewhere, jinni co-exist with and proliferate in spaces of ambivalence, untouched nature, and raw insecurity, including hospitals. Our jinnealogical approach to hospitals tracks the presence of jinn in a state hospital in Gilgit Town, Pakistan-controlled Kashmir, and in a psychiatric hospital in Srinagar, Indian-occupied Kashmir. In his work on human-jinn relations in Delhi, Anand Vivek Tanjea describes jinneaology as the "supersession of human chains of genealogy and memory by the other-temporality of the jinn. Jinnealogy…encompasses the registers of ironic commentary, counter-memory and apotropaic magic" (Taneja 2013:142). The concept of jinneaology resonates with what Jacques Derrida (1994) and other scholars have described as hauntology.[2] While both concepts theorize uncanny and otherworldly presences as repetitions that connect different social, political, sectarian, and ontological orders (see also Langford 2013), the concept of jinneaology is closer to our interlocutors' worldviews. Human-jinn relations illuminate the ambiguously charged, everyday realities of violence, partition, and

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occupation. A jinneaological approach that excavates the spectral thus also provides an alternative to theories of abandonment that have become hegemonic in medical anthropology because it allows us to highlight the simultaneous coexistences and intimacies between beings rendered human and nonhuman. Although we undertook fieldwork independently, here our analysis follows from our shared concern for the spectrality inherent in each hospital. Patients in public hospitals in Indian- and Pakistan-controlled Kashmir frequently summoned, experienced, and endured jinni. For patients, doctors, and hospital staff, jinni's "ghostly signals" expressed a range of fears and concerns that could not otherwise be named, "contained or repressed or blocked from view" (Gordon 2008, 2011:2; Lincoln and Lincoln 2015:193; Pandolfo 2017).

While anthropologists traditionally approach hospital infrastructures as sites of biopolitical governance where populations are managed and lives maximized (or not) through bureaucratic and medical rationality, a jinneaological approach views hospitals not as rational, modern, and future-oriented institutions, but as multidimensional and multi-temporal spaces in which other worlds and neglected histories push through and demand attention in the present. In other words, we evaluate hospitals ethnographically as "tesseracts" (Hinton 1904 [1996]). The tesseract was originally conceptualized by Charles Hinton (1904 [1996]) as a mystical-mathematical means to resist the post-Enlightenment denial of spiritual vocabularies and metaphysical explanatory paradigms, and so reclaim the advantages he felt these offered scientific evaluations of the "higher realities" at work in the world (1904 [1996]:2). Through the tesseract, Hinton described the possibility of time-space slippages and the ghostly visitations and cohabitations they permit. Following Hinton, we take the hospital as the symbolic-spatial mirror of the tesseract's cubit form and square shaping. We argue that, in Kashmir, hospitals are palimpsestic structures with prior lives and histories of violence that are partially remembered, where personal and collective "repressed memories, once stored neatly away, to abruptly resurface without warning" (Walter 2014:57) and are experienced as hauntings.

As a four-dimensional contact zone, the tesseract's value for hospital ethnographies is multiple. Through it, we prioritize the interlacing of: times past and present, worldly and otherworldly forces, the living and the dead (or those deemed "dead"), and humans and nonhumans. The tesseract allows us to resist a static or flattened reading of the experiences, spaces, and perceived realities inherent to bureaucratic places. Instead, we examine the hospital's interior worlds as multidimensional settings in which our interlocutors experience spectrality in medical encounters, as well as ambiguous cohabitations with human and jinni others. By treating hospitals as spaces of ghostly presence, we emplace medicine within chronologies of political violence, and attend to how failed pasts become socially, spatially, and infrastructurally fixed (Bell 1997:832).

Medical infrastructures are not merely structurally and politically informed; they are also defined by intangible, ambiguous, and densely symbolic spectropolitics – the politics *of* specters – that surround, infuse, and even arise from medicine (Blanco and Pereen 2013:19). Through a theological orientation to infrastructure, we follow how patients harness encounters with nonhuman beings, how they may be read as nonhuman beings, and how such moments reveal state neglect. Whether interpreted literally or symbolically, jinni and their hauntings allow patients to indirectly communicate the affective and (im)moral nature of site-bound insecurity, relay hospitals' plurality of associated risks, and signal the socio-spatial transgressions inherent in hospital spaces. In this way, hospitals' earthly precarities are witnessed and measured, and traumas are tied to place. Yet, jinni narratives are even more broadly purposed than this: they offer potent opportunities to speak of past and institutionally forgotten experiences.

In recent years, scholars have attended to the promises, imaginaries, and temporalities of infrastructure (Anand 2011; Günel 2018; Harvey and Knox 2012; Humphrey 2005; Hetherington 2014; Larkin 2013). Rather than the "politics of the present" that characterizes much of this work, a jinneaological approach examines the ghostly traces that stubbornly remain within these topologies or circuits of value (Collier 2011; Graham 2010; Simone 2011). Because jinn embody a temporality

other than the present, they may invoke a traumatic past, portend imminent harm, or reshape the present.

By showing how "unstable" medical facilities produce patient subjectivities and embodied experiences grounded in acute precariousness (Street 2014), we attend to the embodied, engaged, and affective dimensions of the colonial or postcolonial state (Aretxaga 2003; Navaro-Yashin 2012; Saris 2007; Stoler 2013; Taussig 1987). Like others accessing highly triaged state care, Kashmiris cannot voice their fears directly, and their complaints often take immaterial or indirect form. Our dialogical and intersubjective ethnography takes seriously our interlocutors' anxieties as affective registers, which reflect the unwieldy dangers in *and* of hospitals – whether this worldly and immediate, or otherworldly and distant (Blanco and Pereen 2013:13). Our interlocutors' back chatter and claims of uncanny presences – often dismissed by medical personnel and ethnographers – invoke the traumatic holdovers of history, medicine and sociality, made manifest not only by jinni, their visitations and after-effects, but also *by* and *in* bodies (Blanco and Pereen 2013:19). In prioritizing the fear, dread, and eeriness specific to hospital settings, we take sense and sense-making as interpretive starting points, and resist a theorization that over-privileges the rational and bureaucratic capacities of medicine.

Equally, in highlighting jinni's ghostly presences across the Line of Control (LoC) separating Indian from Pakistan-controlled Kashmir, we show how violence, occupation and chronic instability are similarly lived and felt on both sides of the border. This project is thus also a first step in knitting together histories and experiences torn asunder by post-Partition borders and violence.[3] Kashmir is simultaneously one of the most militarized and neglected spaces in South Asia. In 1949, after India and Pakistan ended the first of three wars over the region, Jammu and Kashmir was partitioned: 65% of the territory fell under Indian control; Gilgit-Baltistan was only partially incorporated into Pakistan. Neither India nor Pakistan accepts the LoC as permanent; both claim the entire territory and pledge to restore "normalcy" to this region. Yet, today each region is in its own way overdefined by fractious intraregional cultural, ethnic, and sectarian differences. Meanwhile, Kashmir's liminal status is exemplified by public health infrastructural degradations and neglect. Jinni invite Kashmir's past into our interlocutors' present. For those who encounter them, jinni's apparitional figures materialize and commemorate inarticulatable histories of political unrest, violence, and abuse; their haunting effects signal a "relentless remembering and reminding" (Tuck and Ree 2013).

Specters and ghosts in Kashmir are bound up with political risks, as well as with risks specific to public health institutions. In Varma's ethnography in Indian-controlled Kashmir, jinneaology helps us understand the dialectic of (in)visibility, recognition, and (mis)placedness that structures relations between long-term patients, doctors, and hospital staff in an era of outpatient, community-based psychiatric care. In Varley's ethnography, jinn and other spectral presences materialize social, sectarian, and political uncertainties heightened by long-term occupation and violence in Pakistan controlled Kashmir. In both, jinni exist as inter-temporal entities that connect past and present.

Jinni in closed wards

In 2009, the Government Psychiatric Diseases hospital in Srinagar, Kashmir – the state's only public psychiatric hospital serving six million people – was transformed into a construction site. Groundwork was laid for a new academic block, library, postgraduate hostel, and genetic testing lab. These infrastructural transformations were sponsored by a highly competitive national grant of 300 million rupees ($4.5 million USD) from the Indian government's Ministry of Health and Family Welfare. The grant monies were intended to facilitate the hospital's transformation into one of 11 national Centres of Excellence of mental health research and human resource training (Varma 2016). While Kashmir's only public psychiatric hospital attempted to move toward a more research-based, scientific future, such efforts were haunted by the incomplete, ambivalent treatment of people who were severely mentally ill. Alongside dreams of innovation, prestige and academic excellence, the specter of fear of the severely mentally ill – and the mentally ill as jinni – coexisted in this space.[4]

In line with global trends in psychiatry, including neoliberalization and pharmaceuticalization, the Centre of Excellence model aims to shift care outside institutions into communities – a process referred to as "de-institutionalization" or "community-based care" – while repurposing psychiatric institutions as training centers to help meet India's mental health "human resource" goals (Sinha and Kaur 2011:261).[5] Significant legislative changes emphasize that "community-based" treatment is more humane, effective, cheaper, and accessible than institutional care. For instance, India's 2013 Mental Health Act states: "[L]ong term care in a mental health establishment…shall be used only in exceptional circumstances, for as short a duration as possible, and only as a last resort when appropriate community based treatment has been tried and shown to have failed" (Mental Health Act 2013, Chapter V, Section 18). The era of human resource development and shortened in-patient stays has, however, produced a dilemma of its own: in promoting community-based care, where do chronically ill patients – those residing in institutions – go? (Varma 2016)

Approaching community-based psychiatric care jinneaologically, we argue that long-term, institutionalized patients are both out of place and out of time. Though institutionalized patients continue to reside in the hospital, they are the materialized leftovers of its asylum past. In other words, long term residents of the hospital index the incompleteness of massive bureaucratic and infrastructural projects designed for the future – as such, they are jinn-like. Severely mentally ill patients are analogous to jinn in several ways. Like jinn, they are a separate species of being, different from other humans. This separateness is reinforced by the fact that chronically ill patients reside in "primarily desolate" spaces (Khan 2006:328), that is, isolated, closed wards. Like jinn, who can be disruptive and troublesome presences, chronically ill patients are also "matter out of place" (Douglas 1966) within modernizing psychiatric institutions; institutionalized patients both represent the existence and contravention of an established order, in this case, a manageable madness that can be outsourced to communities. Unlike patients in "open" wards, patients in closed wards are subjected to a limited therapeutic regime, which assumes they will never improve. Finally, institutionalized patients are out of time: they embody psychiatry's repressed memories and shameful pasts of custodial abuse.

Though the Centre of Excellence model was justified through human rights concerns, training and resource development goals were prioritized over patient care. Reform efforts and grant monies were directed toward improving facilities for imagined future mental health experts, rather than patients. To mark its new, higher status as a site of research and training rather than treatment, the hospital was renamed an Institute for Mental Health and NeuroSciences. In India, medical institutes are prestigious research and teaching hospitals. As one psychiatrist told me admiringly, "Institutes [rather than stand alone hospitals] don't just have individuals, they have *teams* of psychiatrists."

While the public areas of the hospital were transformed, the wards where chronically ill patients lived remained untouched. Although institutionalized patients lived in the geographical heart of the hospital, they could not be metabolized within the Centre of Excellence. The work of making long-term patients into jinn-like presences became sharply clear to me one day. While browsing an institutionalized patient's file, I noticed pages of the notation "CST" – continue same treatment. The nurses helped me identify the psychiatry resident whose signature was on the files, and when I asked him about the notations, he told me none of his supervisors expected him to go to the closed wards. He said: "These patients will not get well, generally speaking. There might be one or two, here or there, but those cases will be a miracle."

This statement suggested that different logics of triage were operating in different parts of the hospital. Resources and moral priorities were directed toward outpatient care and fellow mental health experts. Long-term, chronically ill patients were kept alive, fed, and medicated, but they were not expected to improve or recover. They were not being "let die" so much as they were being offered "minimal biopolitics" – predictable doses of medicine, food, shelter, and sanitation that represent *zoë* or bare life, rather than *bios* or a thriving, fulfilled life (Redfield 2013). By providing only minimal care to patients in the closed wards and treating them indirectly through paperwork,

psychiatrists attempted to forget psychiatry's shameful past and invest their energies in more hopeful projects. As materializations of the hospital's previous era of custodial care, the closed wards haunted community-based, humane, and scientific psychiatry. While the rest of the hospital turned resolutely toward a new future, chronically ill patients were increasingly isolated, forgotten, and denied the benefits of the Centre of Excellence.

However, like the thin line that separates jinni from humans, the line between long-term patients and those who were fully human was also permeable, shifting, and affectively charged. Despite staff efforts, the hospital's asylum haunted the Centre of Excellence. Shameful histories of custodial abuse resurfaced in the memories of patients, doctors, and hospital staff, bursting out of the thickets of the past into the present. For example, Shafeeqa, a warden of the closed, female ward, had inherited her job from her mother, who had died a decade earlier.

"Why else would I be here?" Shafeeqa asked me indignantly, one, cold December day in 2010, while we warmed our hands in front of the gas stove (*chula*) in the small, dark staff room. I had asked Shafeeqa if she used to come to the hospital as a child. She nodded, "I used to come here, yes. But I try not to remember those days. Those days, things were much worse. The patients were chained from head to foot." After a pause, she continued, "but then the [Supreme] court order came, and then they stopped chaining."

In her account, Shafeeqa tried to draw a strict boundary between the hospital's shameful past and its more modern present. But though the hospital had stopped chaining patients, its carceral past was still present – in names, language, memories, everyday practices, and the closed wards themselves. The hospital staff still used custodial language to identify personnel and spaces, speaking, for instance, of wardens rather than nurses and closed wards rather than inpatient wards. Despite the hospital's name change, people still referred to it as the asylum (*pagal khana*). While patients were no longer chained, those in the closed wards were still locked inside, except for mealtimes. Sometimes, I heard women drumming on the windows or crying to be let out. Encounters with chronically mentally ill patients were intense and confounding moral experiences for psychiatrists and hospital staff despite their highly technical, biomedical training. When I asked a psychiatric resident about his first year, he described how he had "mixed feelings" toward psychiatry. "I think I was carrying some stigmas associated with it," he said, "I still remember the first time I saw a schizophrenic patient. I felt very afraid of his disease. I wanted to protect myself from it. As a doctor…it has taken some time for those feelings to go away…" The resident's admission of "being afraid" illustrates the apprehension of mental health experts in clinical encounter, especially when dealing with chronically ill or psychotic patients. Rather than situate those feelings firmly in this past, the resident's voice trailed off, leaving open the possibility that he still felt afraid.

In everyday life, too, Kashmiris expressed mixed emotions toward the hospital. For example, when Kashmiri friends or acquaintances learned I was conducting research at the psychiatric hospital, many regaled me with stories of "crazies" (*pagal log*). One friend, Abid, described how when he and his friends first started smoking cigarettes as teens, they would go to the hospital to play a game of chicken. Each would take turns sticking their cigarettes through the bars on the windows of the closed wards. The goal was to hold out a cigarette into the dark interior until a hand emerged and grabbed it. Nawaz described an "eerie" feeling when the disembodied hand emerged from the darkness. Then, they would run away and laugh hysterically. This vignette conveys a sense of the chronically mentally ill as Other, and as other*worldly*. In Nawaz's story, patients in the closed wards are like jinn – at moments visible and at other moments not. At the same time, the narrative recognizes the permeability of the worlds of jinni and humans, the insane and sane, separated only by bars on a window.

Anthropologists have described spaces where the chronically mentally ill reside as "zones of abandonment" (Biehl 2005; Marrow and Luhrmann 2012). Yet, this term does not capture the nuanced relationships between patients in the closed wards and others elsewhere in the hospital. Unlike abandonment, which implies a severe cut between life and death and a sense of "letting die," a jinneaological lens allows us to see forms of intimacy and affect that move among people between

closed wards and other spaces. Like human-jinn relations, relations between hospital administrators and patients were fraught, as well as loving (cf. Khan 2006). As Naveeda Khan puts it, "malevolence and a certain generosity go together" in human-jinn relations (2006:235).[6] I found a similar oscillation between generosity and repulsion at work toward chronically mentally ill patients. Like jinn, those in the closed wards could suddenly become matters of concern.

> One day, in spring 2010, I find Nusrat, a patient from the closed wards near the hospital's gate, out of bounds. She tells me that her father has just died, and she ran away from the hospital to attend his funeral.
>
> "I know, I heard," I tell her.
>
> Her eyes light up. "Who told you?" she asks me eagerly. The happiness in her voice strikes me. The fact that I received this news suggests that she exists within a network of social relations; she is remembered in an amnesiac space. We walk, arm-in-arm, back toward the closed ward where she lives with 21 other women. Her joy is palpable. Various hospital staff see us and call out her name, as if afraid that she might run away again, as if saying her name out loud will affirm her presence:
>
> Nusrat, *chalo!* they shout, *Nusrat, go on*!
>
> Nusrat, *warie?* How are you?
>
> In calling out Nusrat's name and acknowledging her presence, hospital staff make clear that Nusrat is visible to them. Her presence matters, but paradoxically only because of her earlier disappearance.

What does it mean for the hospital staff to call out Nusrat's name, and in so doing, call her into being? Names are extremely significant within Islam, generally, and for human-jinn relations, specifically. In many parts of the Muslim world, the most important event in a child's life is the naming ceremony (*tasmiya*), which usually occurs a week after birth (Dessing 2001:31). In some places, the naming ceremony is accompanied by a sacrifice; without the sacrifice, a child cannot be given a name and consequently cannot be made known to God (Dessing 2001:63). Thus, not only are names central to a child's being in relation to God, but the name is also considered *sunna* – adherence to the portion of Muslim law based on Muhammad's words and acts, accepted as authoritative by Sunni Muslims, who constitute the majority in Kashmir. Jinni's personal names also matter. For example, in rituals involving jinn possession, a crucial first step in the healing process is identifying the jinn by name (Dieste 2013; Østebø 2014:31). Naming, in the case of the jinn and Nusrat, is a means of emplacement and of rendering benign a dangerous force.

However, while jinni like to be named, they do not like to be confined through the use of their name. The staff calling out Nusrat's name captures the double-edged quality of naming. As Judith Butler puts it, "because I have been called something, I have been entered into linguistic life, refer to myself through the language given by the Other" (Butler 1997:38). From this perspective, the staff call Nusrat's name to capture or emplace her in the hospital. Yet, Butler's account of naming does not explain why Nusrat responded positively to the fact that people were talking *about* her. For Butler, being the referent of third person discourse is potentially violent because "the linguistic constitution of the subject can take place without that subject's knowing, as when one is constituted out of earshot, as, say, the referent of a third-person discourse, then interpellation can function without the 'turning around,' without anyone ever saying, 'Here I am'" (Butler 1997:33). By contrast, Nusrat's response to being talked about suggests that naming can be a form of care and recognition (Das 1996; Stevenson 2014). Writing about Inuit naming practices, Stevenson (2014:109) notes, "there can actually be no physical survival, no feeding of the body, without that prior linguistic life, without being given a name." Names, in other words, are essential to a person's existential being and survival. This is perhaps why Nusrat wanted to be talked about.

Like jinni, long-term patients are potentially dangerous, disruptive entities who threaten to undermine modernization projects. But at the same time, chronically ill patients will not – and cannot – disappear from these spaces. This is not a process of abandonment, but rather, it shows how, jinni, chronically ill patients and human others are intimately related to each other.

The preternatural hospital: Haunted wards, ghosted medicine

From Srinagar, where patients take spectral form and medical interactions are fraught by liminality and partiality, we come to Gilgit Town, where hospital-bound spectrality is conjured and made resonant by crisis, and patients seize on jinni as means of traumatic conveyance and political signification. Like Indian-occupied Kashmir, Gilgit-Baltistan has endured concentrated projects of occupation, militarization, surveillance, and restrictions on civil rights. These, when combined with Pakistan's "divide and rule" efforts to pit Gilgit-Baltistan's Shia and Sunni communities against each another, and communities' own efforts to leverage violence as a means to power, have generated deep insecurity and spectacular violence. Shia-Sunni hostilities in Gilgit Town, the region's capital, have resulted in thousands killed and thousands more injured since the late 1970s, and engendered a lasting state of inter-sectarian "tension" that scars social life and haunts shared spaces, including hospitals.

In the women-only Family Wing of the Gilgit District Headquarter Hospital (DHQ), Gilgit-Baltistan's primary referral hospital, sectarian animus and political insecurity have produced intensive effects for patients and providers' experience of the hospital, its services, and medicine itself. Staffed primarily by Shia and Ismaili personnel, the entire hospital is encircled by a Shia neighborhood, from which anti-Sunni protests and violent attacks have been launched. That the DHQ has also been the scene of the targeted killings of Sunni patients, providers and staff by Shia militias only compounds the many other risks posed by the hospital and its services. Sunni patients and staff's on-site insecurities coincide with troublingly high rates of iatrogenic injury and avoidable death; outcomes which growing numbers of Sunnis read as evidence of sectarian-informed differential care, treatment exclusions, and medical abandonment. Yet, Sunnis explained their more distressing experiences of the hospital not simply in terms of the dangers posed by sectarian conflict and its purported spillover into medicine. Instead, the hospital emerged as multiply haunted, metaphorically as well as literally, not only by enmity, but also by agentive entities beyond our easy perception, who were largely unbound by the shackles of time and space. Patients and medical personnel alike insisted the DHQ's wards were populated by ephemeral "presences" – jinni – who were characterized as sentient, agentive, and worryingly unpredictable. Following from Islamic doctrine, they explained how humans share every worldly space – including hospitals – with jinni. They described how a gossamer veil holds them from our objective view, even though we remain always visible to them. Only in rare and exceptional moments, such as psychic or spiritual disruption, was the otherwise imperceptible boundary holding apart our respective cosmological existences diminished, and humans were made aware of and affected by jinni's presences.

By seizing on spectrality to relay the complex atmospherics and diverse forms of affect specific to the Family Wing and interlaced with its services, the distress and suffering given rise by iatrogenesis, enmity, and violence were re-communicated in haunting terms. By re-conveying their earthly perils as cosmological, disempowered and oftentimes-silenced interlocutors were able to voice the otherwise-unspeakable, hazardous circumstances of medical care. The hospital was further haunted by crisis-linked acts of "ghosting," when those targeted for sectarian violence were, for their own safety, secreted away in quiet corners on the hospital premises. Like jinni, they were made partial presences, spectral, only dimly discernible and unspoken. In such moments, otherworldly spectrality and this-worldly insecurity were similarly experienced; through their coinciding effects, each type of haunting was mirrored by its other.

Over multiple fieldwork visits, and especially those which coincided with episodes of Shia-Sunni "tension", patients and hospital personnel spoke more and more often of the "beings" inhabiting the Family Wing. Jinni manifested, women said, most often during the nightshift, a period of time described as the most spiritually fraught and most insufficiently supervised, with specialists largely unavailable and the burden for care resting on under-trained and under-resourced paramedical providers. In the dark night hours, maternal deaths happened with daunting frequency. These were also the hours when patients and providers spoke of beds moving on their own, doors swinging open or slamming shut, lights turning off and on, disembodied voices heard in hallways or in treatment rooms, and persons pushed and pulled:

> Lady Health Visitor Zahida: Patients were saying that the whole hospital bed was moving, and that doors were opening and closing. They came downstairs [from the inpatient ward] to tell us, saying that the movements and sounds were as if there was a wind in the room, but there was no wind.
>
> Lady Health Visitor Sairah: The patients complain of these things, often after midnight, which is the same time the jinn … come.

As supranormal presences erupting into space and consciousness, jinni provoked often-unpleasant sensations and unwanted experiences; these were not dissimilar from patients' and providers' narrated, affective experiences of the hospital itself, and the medical services provided therein. For some, their anxiety and fear were especially sharp when phantasms manifested "out of place," in spaces ordinarily inaccessible or denied, such as clinical suites, off-limits, inoperational, or sealed off. In ways that evoke Pakistan's "ghost hospitals" – in which, because of state neglect, wards are left hollowed out and depopulated, bereft of resources – a midwife shared how late one night, an orderly came to her in distress, crying that, through the glass inset of a padlocked door, she had seen an "old woman with unbound, loose hair" moving about inside the Wing's unused Operating Theatre, which had been shut for years because of lacking funds.

Jinni also made themselves knowable by mimicking the known and, by provoking feelings of familiarity and recognition, moved more easily among us. On one occasion, several staff witnessed the Medical Superintendent – or, his doppelganger – making his usual morning rounds of the Family Wing's wards. To their surprise, later the same day he returned to complete rounds again: "When [he] came again, we said 'Sir, you've come twice today!' and he replied, 'No, I didn't come in the morning', which left us all in doubt." Those staff less rattled by the visitation archly remarked how the ghost-like presence had observed the Superintendent's morning duties even though his physical self had not.

The Family Wing's uncanny multidimensionality was neither exceptional nor strange; even domestic spaces were said to be crowded by spectral forces. Rather, the interlacing of multiple supernatural, social, and structural jeopardies specific to the hospital made ward-based hauntings feel especially, acutely unusual, and over-weighted by this-worldly and otherworldly hazards alike. Such realities meant that haunting was hardly a singular experience. Haunting was instead conveyed as a plurality of fraught states, indexed not only by degrees of social and spatial insecurity, but also by the co-existence of threatening and strange forces past and present, seen and unseen. When considered against Gilgit's recent violence, for instance, jinni's erratic interferences served as potent metaphors for the uncontrolled and intertwined risks of sectarianism and medicine. For Sunnis, these twinned risks were largely unspeakable on account of the endangerments they associated with hospital spaces and personnel, and by the close presence of sectarian others, of whom they were both afraid and entirely dependent for care.

Sunni women admitted to the Family Wing especially described how their treatment and security in hospital spaces hinged on peaceable inter-sectarian bonds between themselves and sectarian others, whether staff, patients, and attendants. This meant that while on hospital premises, especially during times of "tension," many delivering mothers internalized much of the angst they felt at the prospect of medical treatment provided across sectarian lines. While at the hospital, they imparted their concerns only with great difficulty, through rushed, whispered testimonials shared with family, other patients, or the few Sunni staff employed at the Family Wing. Precluded from directly or easily accusing sectarian others of malintent or wrongdoing, or giving voice to the diffuse enmities they felt haunted ward life and treatment encounters – for fear such claims would be taken as provocation and lead to amplified risk and even violence – women found other ways to channel their anxieties. For them, the jinn's presence facilitated the naming of terror and its proximal sources.

Mortality featured strongly in many such narratives. In summer 2005, one expectant mother, whose husband's cousin was killed at the hospital during Shia-Sunni conflicts that January, denied being afraid of the threats posed by sectarianism at the hospital site. With her ability to engage in

explicitly sectarian claims-making at the hospital circumscribed by the imminence of "tension" and the dangers it portended, Lalparri narrated her apprehension and avoidance of the hospital and its services in exclusively spectral terms:

> I'm scared to go to the DHQ [because] it's a bad and dangerous place. I'm scared of the room with the dead bodies at the back of the Family Wing. I used to go to school there, … and I knew there were dead bodies there, *Allah tobah!* [God forbid]…I [also] have a fear of [the] DHQ because I have fears of jinni, and people told me there were jinni there.

In this telling, contemporary clinical places of birth were psychically conflated with past spaces of death. Her memories of the morgue, which had once stood in place of the Family Wing, were strong enough to override the maternity ward's present status as a place of healing and birth. Through these expressed fears, the morgue of the past alluded to perils in the present: high rates of obstetric and neonatal injury and loss, and even the killings of Sunnis by Shias in ward-spaces (Varley 2016). Yet, to speak of jinni involved risk. In much the same way that speaking to sectarianism was imagined as an act of provocation, to name the jinn was thought dangerously instigative, capable of conjuring up other even more unwieldy possibilities, such as their spectral attacks or possession. There were, therefore, deliberate hesitancies threaded into Lalparri and other women's relays both of sectarian and jinni presences. Visibly frightened, Lalparri's sister had described how at night, not only the Family Wing but also the male wards that neighbored it, could be experienced as wholly transformed, as a death-saturated and spirit-populated paranormal hyperspace:

> It was late at night when [my brother-in-law] arrived [at the hospital] … and went into a room full of light, and people all dressed in white. He … asked the *chowkidar* [guard;] there, 'Who are the people in that room?' The *chowkidar* said, 'You're lucky, because they left you [alone]…many dead people were brought here today!' My brother-in-law went back to that room to see for himself after, and it was empty.

Other interlocutors spoke of jinni frequenting the ruins of colonial-era wards at the Family Wing's margins. In 2012, while walking across the site in the late evening, one of the Family Wing's dispensers had behind him heard a disembodied voice – *aaaah*. He turned to see "an arm only" materialize briefly in the air in front of him. In trying to make sense of the story, his colleagues spoke of *where* it happened:

> In that very space, the old [colonial-era] hospital had once stood, when there were tall *chenar* [maple] trees … crowded all around the site. These had been planted during the Maharaja of Kashmir's day, before Partition. But to build the new Family Wing, they had to cut those trees down, so maybe that upset the jinn who lived among the *chenar*?

They understood the jinn's appearance as an echo of a distinctly political past, the trace effects of which percolate through time to disrupt the present. Though initially dislocated during the sharp segue from colonialism to postcolonialism, the jinn remained steadfastly resident in the hospital's repurposed space. By manifesting and resisting its displacement, the jinn's presence signaled a spiritual-temporal slippage, which allowed pre- and post-Partition histories to be remembered and rejoined. In this way, under-spoken or even dormant memories were sparked, sustained, and renewed, and the inactive past made active again. Reaching further, jinn were not simply reverberations of histories prior. They suggested the possibility of past and present as not merely contiguous, but co-present, enmeshed, and even simultaneous happenings.

When considered alongside Lalparri's recounting of the maternity ward as morgue, such stories suggest the complex imprinting of loss on physical geographies, and the rising up of trauma through soil, space, and infrastructure to unsettle the present. They further show the potential for jinni to be narratively seized as otherworldly stand-ins for this-worldly forces and crises, and invite more expansive ethnographic interpretations. We may evaluate jinni for their instrumental usefulness as ciphers, symbolic devices onto which diversely non-spectral meanings and messages were overladen and grafted, and angst and lament more safely, though not always apolitically, conveyed. Because

stories of haunting and "ghosting" accrued even greater force when coincident with terror, they permitted some interlocutors to pursue the political through the traumatic (see Colvin 2004:73).

During conflict and its uncertain aftermaths – when peace was tenuous, the hospital's boundaries poorly protected, and on-site security unreliable or absent – supernatural experiences were not merely spiritually significant but politically compelling. Unmistakable parallels emerged in women's sectarian and spectral experiences of ward life. Jinni's spectral interferences, their ward-wide movements and activities, closely mirrored Sunni interlocutors' memories of Shia gunmen's traversal of wards and attacks on Sunni patients during crises past (Varley 2016). While in one story, interlocutors catalogued the "non-Muslim" and capricious immorality they attributed to some jinn, in subsequent narratives they protested the unpredictable, impulsive, and even "unIslamic" behavior attributed not only to *deshatgard* (terrorists), but sometimes also Shia medical personnel and even other patients. My interlocutors' anxieties were further amplified by their belief that jinni and sectarian others were capable of and sometimes intent on producing injurious and even fatal outcomes. This did not mean that spectral affects and vulnerabilities were primarily or most harmfully borne by Sunnis. In reiterating and narratively extending on Sunnis' spectral claims, and emphasizing their endurances of these same forces in the same ward settings, Ismaili and Shia providers confirmed their investments in a shared rather than sect-exclusive cosmology. Such claims stood in contrast to the sectarian divide, which otherwise held the communities apart, and delimited narrative recognition of each other's fears and insecurities. More so, in affirming common experiences of insecurity and belief both, these accounts carried the potential to engender parasectarian affinity and empathy.

Unspoken by my interlocutors, yet ethnographically observable, were the ways the Family Wing's wards were haunted, too, by the "ghosted" living. Even though Sunni women patients were not the targets of sectarian violence, during crises their attending male family members were. When tensions peaked, such were the persons "ghosted" by others within the site, their presences denied and made temporarily and deliberately invisible by acts of "disappearance … and social erasure" (Blanco and Pereen 2013:10). In 2012, while I was observing a delivery in the Labour Room, an Ismaili midwife quietly asked the patient, a Sunni, where in the Family Wing her family was waiting. Following the midwife across the ward as she tried to find the patient's male relatives, I came across other staff making similar efforts with other patients' families.

The midwife shared how, an hour earlier, a Gilgit-bound wagon filled with Shia travelers was destroyed by an improved explosive device buried into the roadway over which the vehicle passed; the police surmised it had been detonated by radio control. The incident had happened in a Sunni village at Gilgit Town's edge, and now multiple Shia casualties and the bodies of several dead were being brought to the DHQ by a fast growing crowd of mourners and protesters, who, staff worried, might seek out and harm Sunnis on-site in retaliation. Like spectral interferences, retributive acts of violence had happened at the hospital before, and could happen again. The staff cautiously gathered the men together in an empty patient room; its inside drapes were drawn, and the door shut and locked from the outside. There, soundlessly, the men were expected to wait until the "tension" – which by now had reached the hospital along with the victims' bodies – abated. The staff's methodical shepherding of men into an interim yet also inescapable "safe" space[7] confirmed the hazards Sunnis faced at the hospital, and the saving power of active inter-sectarian empathy, which came at no small risk to Sunnis' Shia and Ismaili rescuers (Varley 2016). In ways that mirror Varma's analysis of ward-bound psychiatric patients as being akin to jinni on account of their separation, strangeness, and "incompleteness," there were poignant parallels between the unspoken, obscured, and partial presence of men secreted away in darkened patient rooms, and the uncertain, halfway-present spectral entities inhabiting the site.

Recuperative and protective agencies both were made possible by naming angst, insecurities and their sources in broadly spectral terms, with hauntings serving as the pretext for some interlocutors' efforts to escape the hospital and its associated dangers. To this end, jinni emerged as neither alien to nor separable from medicine, but inextricably bound up with its local practice and outcomes. My

interlocutors' spectral claims served, too, as forewarnings of a sort: that they were vigilant to the conditions of care and the histories and intentions undergirding treatment encounters, even as they also remained largely unable to articulate let alone mitigate the harmful mechanics at work in their interactions with sectarian others, and bound to space and place. Reinforced by the ever-present asymmetries of power specific to the DHQ, the need for certain kinds of silence remained. Yet, by harnessing hauntings to establish the tangibility of violence, its immanence, and its sources, women could give voice to terror and insecurity when other forms of voice became impossible.

Conclusion

In elaborating how hospitals' structural and political hazards are interpreted and configured spectrally, we understand hospitals as transgressive spaces laden with social and medical threats, unwanted transformations, and death (Walter 2014:57). Like many scarred spaces, Srinagar and Gilgit's hospitals are imagined, experienced, and memorialized as multiply haunted by the past, the structural, symbolic and direct violence of the present, and crises that threaten to erupt in the near future. A jinnealogical approach draws us nearer to the nature of this haunting, and reveals the multiple relational, sectarian, and cosmological entanglements that suffuse hospital spaces over time. Because it accounts for the temporal and affective oscillations of interpersonal hospital relations, a jinnealogical framework helps us better understand what is at stake in naming and recognizing spectral presences especially.

As phantasmic figurations that materialize in hospitals amidst or because of precarity, violence, and injustice, jinni are laden by immaterial, material, and symbolic properties. For example, in Gilgit's DHQ, jinni's ghostly holdovers and presences were dually interpreted – first, as ontological co-presences, and second, more instrumentally, as metaphors for the persistence and imminence of social fractures, and sectarian and even also medical imperilment. Some interlocutors hypothesized the genesis for spectral materializations was in the tensions dividing Shias from Sunnis, which generated this-worldly strife, enmity, and trauma, and corrosively ate away at the psychic boundary normally separating us from otherworldly beings. For them, the DHQ was dually and simultaneously haunted by the uncanny coincidence of jinni and the loss of conviviality between Shias and Sunnis. For other interlocutors, spectral narratives constitute memory-work, where the past was invoked to explain the fearful present (Blanco and Pereen 2013:19).

Similarly, in the psychiatric hospital in Srinagar, chronically mentally ill patients are jinn-like figures who embody the incompleteness of global and national projects enacting modern, scientific, and humane psychiatry. While hospital staff and doctors try to forget these presences, for example, by treating through chains of "continue same treatment," these presences reassert themselves. Like jinni, long-term residents of the hospital appear and disappear at their own volition and require acts of recognition and care, such as naming, to remain congenial and stable. A jinneaological approach thus reveals the ambivalent but closely-knit relations that exist between the chronically mentally ill and their more "human" others.

By foregrounding public health infrastructures as preternatural, theological, and otherworldly spaces, we see hospitals beyond Weberian rational "ideal institutions." As spaces giving rise to conflict, iatrogenic injury, and death, many Kashmiris see hospitals as archives or even crypts, in which insecurity, injustice, and violence are endured, remembered, and erupt into the present as hauntings (Walter 2014:57). In Kashmir, patients, hospital spaces, and medicine itself are haunted by unacknowledged crises, ambient trauma, and memory's unstable contours. Feelings of anxiety, fear, revulsion, and animus flow freely and unpredictably in these spaces, giving rise to voice, agency, and action that function both symbolically and instrumentally.

In hospital settings located within occupation's brutalizing projects of structural exclusions and sustained conflict, jinn provoke ethical and political opportunities to grapple with the co-presence of past and present, assailants and victims, the social and the medical, and occupying states and occupied citizens. Our ethnography goes beyond accounts of structural vulnerabilities in health

institutions to prioritize how fear and even horror are embodied and produced by places simultaneously marked by political and medical violence. In Gilgit, ghostly apparitions and invocations acted "as political and moral resource[s]" for making claims in the present (Lincoln and Lincoln 2015:193) and indexing trauma's incremental effects. Similarly, in Srinagar, Nusrat's agentive disappearance signaled the hospital's failure to consider the lives of institutionalized patients and forced staff to recognize her.

Together, these multiple hauntings offer a new way of theorizing hospitals as multidimensional and multiply temporal. Nested amid the hospital's interior domains is the physically and psychically real fourth dimension, a hyperspace in which history's spectral traces, ghostly forms, and their varied interferences, proliferate and haunt the present. Rather than treat our interlocutors' meditations on spectrality as illusory, or only as metaphorical figurations of repressed memories and anxieties, theorizing hospitals as tesseracts allows us to recognize these spaces as temporally rhizomatic and spatially multipurpose. We can also account for how actors experience medical infrastructures as spatially overwritten and internally animated by interactive ghostly-human and nonhuman-jinn presences, in which the spectropolitics of the past come alive in the present. There are political claims and "a way of calling for justice" (Till, cited in Pile 2005:235) inherent in such projects of worlding; by attending to them, we may better appreciate the gravity and symbolic reach of wards literally and metaphorically haunted by jinni. These presences and the angst and fear they sparked often crowded into our interlocutors' memories of hospital spaces, and underpinned their future medical trajectories and care decisions.

The tesseract further allows us to bridge the different ontologies at work in anthropologists' and their interlocutors' evaluations of the world. In our meditations on the tesseract, we strive to more closely sense the world as our interlocutors do, and, like them, perceive "things in the same space but in different dimensions," sensed as well as extrasensory (Crabb 2015, para 19). Given the continuities between political and medical violence and the intense disruptions taking place in medical sites globally, through this article, we call anthropologists to further consider how other hospitals might be tesseracts, too.

Notes

1. In our fieldwork from 2004 to 2017, we found that while domestic disturbances were frequently attributed to jinn, their agency was only rarely implicated in sectarian or political violence.
2. For Derrida (1994), hauntology does not only refer to spectral apparitions, but to a larger philosophical process, namely that all being is inhabited by absence. For us, this philosophical insight resonates with our own ethnographic findings that life implies death and that the living exist always in relation to the dead.
3. Until recently, Kashmir Studies was dominated by policy-oriented approaches examining Indian or Pakistani state claims and counter-claims on the region, the insurgency in Jammu and Kashmir since 1989, and crises of sectarian discord and conflict in Gilgit-Baltistan. However, recent scholarship has shifted away from the political aspects of the territorial conflict to a more people-centric approach. Due to the logistical difficulties of cross-border research, however, there has been little empirical work *across* the Line of Control.
4. I thank Reviewer 2 for this felicitous phrasing.
5. According to a 2005 report on mental health conducted by the WHO, there are about 0.2 psychiatrists per 100,000 people in India, significantly lower than the global average of 4.15 psychiatrists for 100,000 people.
6. Khan writes, "by *malevolence*, I mean something that holds out the possibility of harm, rather than actively intending it. By *generosity*, I mean the willingness to concede to others, rather than a nobility of character" (Khan 2006:248).
7. The routinized way in which Sunnis were hid confirmed both that hospital personnel were familiar with sectarian violence, and the insecurities generated by enmity were neither exceptional nor rare.

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